USAID | CARIBBEAN
FROM THE AMERICAN PEOPLE

HIV/AIDS HEALTH PROFILE

Overall HIV Trends

Outside of sub-Saharan Africa, the Caribbean has the highest HIV prevalence in the world. In 2006, AIDS was one of the region's leading causes of death among adults aged 15 to 44, claiming the lives of an estimated 19,000 people. That year alone, approximately 27,000 people were newly infected with HIV, according to UNAIDS. The number of people living with HIV/AIDS in the Caribbean is estimated to be 250,000. Nearly three-quarters of them are from two countries: Dominican Republic and Haiti. National HIV prevalence rates are high throughout the region: 1 percent to 2 percent in Barbados, Dominican Republic, Jamaica, and Suriname; and 2 percent to 4 percent in the Bahamas, Guyana, Haiti, and Trinidad and Tobago. The epidemic in the Caribbean is fueled by a culture that encourages having multiple sexual partners, a thriving sex industry, and men having sex with men (MSM). A 2005-2006 behavioral surveillance survey from six Eastern Caribbean countries found that 31 percent to 46 percent of the surveyed population aged 15 to 24 had multiple sexual partners within the last 12 months. Prevalence in the MSM group may be underestimated because of the stigma attached to sexual relations between men, the often hidden nature of this behavior, and the fact that some men who have sex with men also have sex with women. Furthermore, given the poor quality of epidemiological data in the region, the HIV status of most people is not known. Therefore, the true magnitude of the epidemic is not known. Young women also face considerably higher odds of becoming infected than do young men (UNAIDS, 2005), something exacerbated by cross-generational sex and the "sugar daddy" phenomenon (i.e. reliance of younger women on older men for material needs, often basic, in exchange for sex). New infections among women are surpassing those among men in the Caribbean. Whether this is because women are more likely to be HIV-infected or are more likely to be tested, and therefore to know their status, remains unclear.

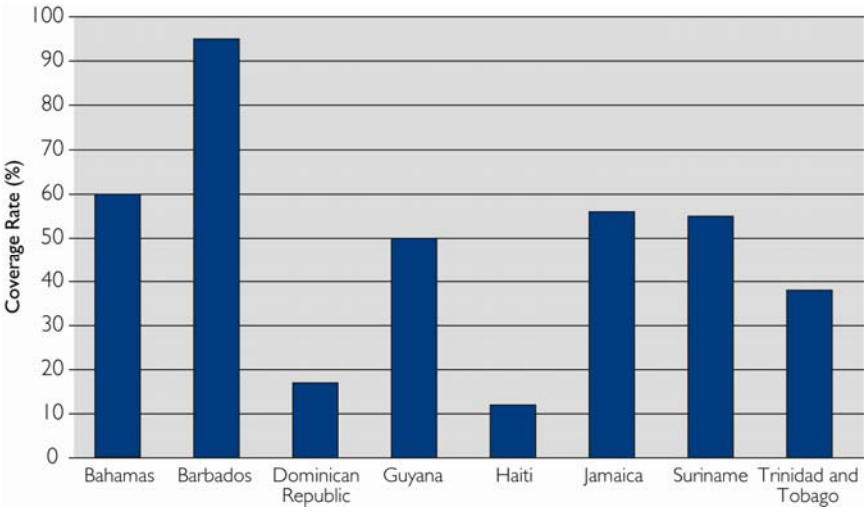
Region-Specific Factors

There are a number of important factors driving the epidemic that are characteristics unique to the Caribbean. Stigma and discrimination is an important issue that prevents the population from getting tested. Due to the small size of many islands and the lack of confidentiality policies, a person walking into a facility is often observed by a neighbor or a friend. Often people travel to other islands for HIV testing due to perceived weaknesses in confidentiality. Addressing stigma and discrimination will require a comprehensive multisectoral response that includes changing social and cultural beliefs and behaviors and modifying policies at the government, employer, and educational levels.

Other important factors include a cultural double standard and sex tourism. There is a large gap between what the population considers to be the ideal and what is actually practiced. There is stigma associated with multiple partners for women but not for men. Although many young people are engaged in high-risk behaviors, cultural and religious taboos prevent frank discussions with young people about sex. Sex tourism is also a unique problem. Overseas tourists demand commercial sex services, exposing islanders to sexually transmitted infections (STIs) including HIV.

The Caribbean's status as the second most HIV-affected region in the world masks substantial differences in the extent and intensity of the epidemic throughout the region. In urban areas of Haiti, new infections have declined. HIV prevalence in pregnant women decreased from 9.4 percent in 1993 to 3.3 percent in 2004. However, localized trends suggest the need to protect against a resurgent epidemic. Preventive behaviors are still not the norm in Haiti. For example, in rural areas, only 16 percent of women and 31 percent of men used a condom the last time they had casual sex (UNAIDS, December 2006). Recent data from the Ministry of Public Health and Population also indicate that in some areas, the prevalence of HIV infection among young women is twice that of young men.

HIV-Infected Men and Women Receiving Treatment in High-Prevalence Countries in the Caribbean, 2006-07



Source: UNAIDS Web Site 2007.
Data from the Bahamas are from Ministry of Health 2006 and include children in the treatment rate.

In the **Dominican Republic**, the country's epidemic is driven by those with multiple sex partners, younger women in union with older men, sex workers and their clients, and MSM. According to the latest Demographic and Health Survey, 29 percent of men had sex with more than one partner in the last 12 months. Women younger than 24 years are also more than twice as likely to be infected as men in the same age group. It is a relatively common practice for young women to establish relationships with older men, who are more likely to have acquired HIV. In the Dominican Republic, HIV prevalence in pregnant women was relatively stable for many years. However, 2005 sentinel surveillance data reported HIV prevalence greater than 4.5 percent in pregnant women at two sites. In the 2006 sentinel surveillance, four sites reported seroprevalence of 3.4 percent and one reported 5.9 percent in pregnant women of all ages. As reported in a recent study, pregnant women ages 25-34 had seroprevalence greater than 8 percent at two sites. The same study reported that seroprevalence in commercial sex workers is 4.1 percent (2.4 percent to 6.5 percent), and in STI patients, it was found to be 4.4 percent (2.48 percent to 7.18 percent). However, in Santo Domingo National District, antenatal clinics have noted a decline in HIV prevalence, probably due to a successful prevention campaign. Prevalence in sex workers has been declining for the last eight years and is reaching the same level as in pregnant women. This may be attributable to the successful implementation of the "100% Condom Strategy" implemented through two NGOs in several provinces with high tourism. For example, condom use among sex workers increased from 75 percent to 94 percent in just 12 months with one community project. A 2005 study in three cities (including the capital, Santo Domingo) found that 11 percent of MSM were living with HIV. Infection levels among sugar cane plantation workers living in communities called *Bateyes* average 5 percent, with some groups as high as 12 percent.

The **Bahamas** has one of the highest HIV prevalence rates in the region at 3.3 percent. Nonetheless, HIV infection levels are falling among pregnant women and persons attending STI clinics. The Bahamas has been particularly successful in using antiretroviral treatment (ART) to reduce mother-to-child transmission and the number of deaths due to the disease.

In **Guyana**, the second poorest country in the Caribbean, AIDS is ranked as one of the leading causes of death among 25- to 34-year-olds. HIV has spread from high-risk populations, mainly commercial sex workers and MSM, to the general population, and the adult HIV prevalence rate is estimated to be 2.5 percent. One study in three regions demonstrated an HIV prevalence rate of 27 percent among sex workers. In a Behavioral Surveillance Survey of MSM in the Demerara-Mahaica region, 21 percent were HIV-positive.

In **Jamaica**, HIV prevalence has stabilized at 1.5 percent. However, the epidemic has spread from traditionally high-risk groups, such as sex workers, to the general population. Two factors contributing to the epidemic are a culture of multiple sex partners and the phenomenon of older men having sex with younger women. A 2004 Behavioral Surveillance Survey demonstrated that 31 percent of males and females aged 15 to 24 had participated in risky sex with a nonmarital or noncohabitating partner within the last 12 months. Fifty-six percent of males and 16 percent of females had multiple partners within the last 12 months. New

infections among young women are surpassing that of young men. Earlier studies in Jamaica indicated that teenage girls were 2.5 times more likely to be infected than their male counterparts. One reason is the relatively common practice of young girls establishing relationships with older men. By virtue of their age, older men are more likely to be infected with HIV than younger men. One study in Jamaica demonstrated that young women in economically desperate circumstances may exchange sex for money, food, or other favors. When the man is significantly older than the woman, this is called the "sugar daddy" phenomenon. HIV infection rates among sex workers are much higher than the general population. Among patients attending STI clinics in Kingston, St. Andrew, and St. James, HIV infection rates reached 5 percent. One study among female sex workers found that 9 percent were HIV-positive. Sex workers who were older, less educated, and used crack cocaine were more likely to be infected. Crack cocaine was also a risk factor for HIV infection among women in Trinidad and Tobago.

Several countries are making progress in providing access to ART. This is especially true in Barbados, Jamaica, Guyana, and Suriname (See graph). Barbados' balanced approach to prevention and treatment is demonstrating results. HIV infection in young pregnant women fell from 1.1 percent in 2000 to 0.6 percent in 2003. A steep decline in HIV deaths from 34.2 per 100,000 to 17.2 per 100,000 has occurred since the introduction of ART in the late 1990s. Guyana's ART program reached half of the infected population that are eligible for treatment and may help to reverse the trend of rising deaths due to the disease.

However, ART is expensive and access in the Caribbean is highly uneven, with some of the worst-affected countries – such as Haiti and the Dominican Republic – having the lowest rates of ART coverage, at less than 20 percent. Lower prices from pharmaceutical companies and assistance

HIV Estimates in High-Prevalence Caribbean Countries	
Bahamas	
Total Population	305,655
Estimated Number of Adults and Children Living with HIV/AIDS	6,800
Adult HIV Prevalence	3.3%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-
Barbados	
Total Population	280,946
Estimated Number of Adults and Children Living with HIV/AIDS	2,700
Adult HIV Prevalence	1.5%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-
Dominican Republic	
Total Population	9,365,818
Estimated Number of Adults and Children Living with HIV/AIDS	66,000
Adult HIV Prevalence	1.1%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	2.5 – 12% (2006)
MSM	11% (2005)
Guyana	
Total Population	769,095
Estimated Number of Adults and Children Living with HIV/AIDS	12,000
Adult HIV Prevalence	2.5%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	26.6% (2004)
MSM	21.3% (2004)
Haiti	
Total Population	8,706,497
Estimated Number of Adults and Children Living with HIV/AIDS	190,000
Adult HIV Prevalence	3.8%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-
Jamaica	
Total Population	2,780,132
Estimated Number of Adults and Children Living with HIV/AIDS	25,000
Adult HIV Prevalence	1.5%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	20% (2002)
MSM	30% (1996)
Suriname	
Total Population	470,784
Estimated Number of Adults and Children Living with HIV/AIDS	5,200
Adult HIV Prevalence	1.9%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	21% (2005)
MSM	-
Trinidad and Tobago	
Total Population	1,056,608
Estimated Number of Adults and Children Living with HIV/AIDS	27,000
Adult HIV Prevalence	2.6%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-

*Multiple partners and cross-generational sex were not included in this table because HIV prevalence data does not exist for those populations.

from donors has been especially important in providing HIV treatment in the region. The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria[1] funds ART for the Organization of Eastern Caribbean States (OECS) countries; and Brazil provides free ART to 500 persons living with AIDS in Caribbean Community (CARICOM) countries. While access to ART has increased appreciably, there is still a need to scale up prevention efforts so as to better prevent the many new infections occurring each year.

Economic and Social Impact of HIV/AIDS in the Caribbean

HIV infections are increasingly affecting the younger and most economically productive segments of society. If unchecked, the epidemic could impact national economies, as evidenced by high-level epidemics in sub-Saharan Africa. The 20- to 49-year age-group is most affected in the Caribbean, accounting for over 65 percent of positive cases annually. Younger women are particularly affected. In Haiti, AIDS is the leading cause of death among adults aged 15 to 44. In the Dominican Republic, life expectancy is estimated to be three years shorter than it would be in the absence of AIDS (UNAIDS, 2006); and AIDS is reported to be the principal cause of death in women of reproductive age. This changes a population's demographic structure and poses a challenge to the systems for supporting dependent populations, such as children and the elderly. Trinidad and Tobago's population is already decreasing due to out-migration and AIDS is expected to further reduce the overall population size by 2010.

The economic and social effects of HIV/AIDS are felt from the family level, where families experience incapacity and death of loved ones and providers must cope with the burden of caring for the sick and dying, to businesses, schools, hospitals, and other institutions that suffer the loss of valuable personnel and declines in productivity. One study predicted that the Gross Domestic Product (GDP) in some Caribbean countries could be reduced by as much as 4 percent because of the disease. The economic costs of addressing HIV and its effects, both in the health and economic sectors, divert resources away from other important investments that are critical to economic development. In many cases, the impact of the epidemic on families, communities, and countries affects the epidemic's future course. For example, if HIV/AIDS contributes to poverty and the breakdown of social and economic systems, that can facilitate the spread of the infection.

Finally, HIV/AIDS has orphaned an estimated 250,000 children in the Caribbean, many of whom will lose their childhoods, forced by circumstances to become producers of income and food or caregivers for sick family members. They suffer their own increased health problems related to increased poverty and inadequate nutrition, housing, education, clothing, and basic care and affection.

National/Regional Response

Although small in absolute number of cases compared with other global HIV/AIDS "hot spots," the Caribbean's fragile small island economies and the second highest regional HIV/AIDS prevalence rates in the world make it a high-profile region in the global fight against AIDS. The high rate of intraregional mobility and interdependence makes regional coordination an important part of addressing common concerns in the response to HIV/AIDS, which is easily transmitted across borders.

Most Caribbean countries have taken measures to control the epidemic. By the end of 2006, 21 Caribbean countries had National Strategic Plans on HIV/AIDS. However, the national health care infrastructure in many countries is not adequately equipped to address the individual and societal challenges posed by the epidemic, including stigma and discrimination; cost of prevention, treatment, care, and support services; loss of income and jobs; reduced tourism revenue; and diminished productive labor in key sectors due to the reduced life expectancy of young people.

Most national-level activities are supported by a coordinated regional approach articulated in the Caribbean Regional Strategic Framework by the Pan Caribbean Partnership on HIV/AIDS (PANCAP), initiated in 1998 as the Caribbean Task Force on HIV/AIDS to scale up the response to the epidemic in the region. The framework, developed under the leadership of Caribbean Community and Common Market (CARICOM), with input from other regional organizations, national governments, and bilateral and multilateral donors, identifies seven interrelated priorities best addressed at a regional level:

- Advocacy, policy development, and legislation
- Care, treatment, and support of people living with HIV/AIDS
- Prevention of HIV/AIDS transmission among young people

[1] The United States government provides one-third of the funding for the Global Fund.

- Prevention of HIV/AIDS among most vulnerable groups (including MSM, sex workers, prisoners, military personnel, and transients)
- Prevention of mother-to-child transmission (PMTCT)
- Strengthening national and regional response capability
- Resource mobilization

USAID works in collaboration with several regional organizations integral to the region's HIV/AIDS response, including the principal technical public health organization for the region, the Caribbean Epidemiology Center (CAREC), which mainly serves the Eastern Caribbean. CAREC is administered by the Pan American Health Organization, Regional Office of World Health Organization (PAHO/WHO), and its mission is to improve the health status in 21 member countries by advancing technical capacity in epidemiology, laboratory technology, training, and research. PANCAP, PAHO, UNAIDS, and, in the case of the Dominican Republic, the Clinton Foundation (CHAI) were also instrumental in negotiating with pharmaceutical companies for lower-priced ART for 15 Caribbean countries. The Caribbean Coalition of National AIDS Program Coordinators (CCNAPC), a peer-based organization dedicated to improving the quality of national AIDS programs, has also emerged as a key coordinating body for the Caribbean in the fight against HIV/AIDS. UNAIDS is also expanding its Caribbean presence.

USAID Role

USAID plays a lead role in helping coordinate the activities of several U.S. government (USG) agencies in the region, including the Centers for Disease Control and Prevention (CDC), the Peace Corps, the Department of Labor, and the Department of Defense. Haiti and Guyana are two of the 15 focus countries supported by the President's Emergency Plan for AIDS Relief (PEPFAR), a five-year $15 billion initiative to turn the tide in responding to the global HIV/AIDS pandemic. All other Caribbean countries that receive USG HIV funding through USAID also benefit from PEPFAR funding as non-focus countries. USAID also works with the Global Fund to Fight AIDS, Tuberculosis and Malaria, other donors and development banks, UNAIDS, and PAHO/WHO, which have brought crucial resources and technical capacity to the region's fight against HIV/AIDS.

The USG is the major contributor to the Global Fund and is leveraging Global Fund resources in HIV/AIDS for maximum results in the Caribbean. USAID is coordinating with the Global Fund to scale up the Caribbean regional response to the HIV/AIDS epidemic through PANCAP, the OECS, and the organization of people living with HIV/AIDS, CRN+.

USAID is an active member of PANCAP, providing HIV/AIDS support on both a bilateral and regional basis. Bilateral support is provided through USAID missions, while the Caribbean Regional Program provides technical support for countries without a bilateral mission. USAID's Caribbean Regional Program also conducts activities designed to help local nongovernmental organizations (NGOs) and national and regional organizations mount a coordinated, multisectoral response to the epidemic. The 2005 to 2009 strategy for the regional HIV/AIDS program is to build on previous interventions to support national and regional efforts addressing HIV/AIDS issues, primarily expanded HIV prevention, treatment, and care services; improved monitoring of the epidemic; and further prevention of HIV transmission in high-risk groups. USAID focuses on high-risk and vulnerable populations in both high- and low-prevalence countries. Cross-cutting themes include reducing stigma and discrimination, increasing preventive and behavior change efforts, and putting more focus on gender issues that put young women at risk for HIV/AIDS. Specific areas of regional activities include support for PANCAP, CAREC, nongovernmental networks, and the Caribbean Regional HIV/AIDS Training (CHART) network of centers.

USAID Regional Support

CAREC

USAID provides support to CAREC to prevent the spread of HIV and minimize the impact of AIDS by strengthening national and regional capacity in the areas of research and improving diagnosis, care, and treatment for TB/HIV programs, and providing information to target behavior change interventions at groups most likely to acquire and spread HIV. From 2003 to 2007, USAID provided financial resources and worked in collaboration with CAREC to execute and publish Behavioral Surveillance Surveys in Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines. These surveys provide information on critical gaps in HIV/AIDS services and on high-risk behaviors driving the epidemic.

Nongovernmental Organization Networks

USAID's regional program supports the strengthening of managerial, technical, and administrative capacities of NGOs involved in HIV/AIDS prevention activities, and works with national governments in public-private partnerships to develop multi-year HIV prevention plans. USAID supports networks of NGOs in six countries in the Eastern Caribbean that are working with national governments to reduce HIV transmission among high-risk populations. Members of the networks receive training in financial sustainability, governance, income generation, and monitoring and evaluation. In the current strategy, USAID works with local partners to target three population groups: sex workers, MSM, and people living with HIV/AIDS. USAID is in the process of shifting its focus from high-risk groups to high-risk behaviors, because behavior is what places someone at risk and it is not always easy to categorize a person into a specific high-risk group. The Agency supported 18 prevention programs in nine countries that targeted behavior change interventions for more than 8,000 people, most of whom were hard-to-reach vulnerable populations. Activities included organizing training workshops on education and prevention of HIV/AIDS, interpersonal skills building and behavior change to reduce the likelihood of HIV transmission, and advocacy work with regional bodies to promote the rights and needs of members of key populations.

Regional Training Centers

As governments and NGOs scaled up activities to meet the demand for care, it became apparent that the Caribbean region had a shortage of health care providers trained in HIV/AIDS. To address this need, the Regional Program collaborated with CDC, HRSA, and the University of the West Indies to establish a network of HIV/AIDS training centers in the region. Known as the CHART (Caribbean HIV/AIDS Regional Training) network, this initiative led to the establishment of a total of six training centers in Jamaica, Bahamas, Barbados, Haiti (2), and Trinidad, providing training to health professionals in more than 30 countries in the region. The CHART initiative is funded by USAID/Barbados under a 5-year cooperative agreement through 2009. In 2006, 691 HIV/AIDS service providers were trained and then provided services in 315 voluntary counseling and testing (VCT) sites and 46 ART clinics. Additionally, more than 7,000 HIV-positive patients received ART at these 46 clinics. The Caribbean program continues to expand the number and quality of VCT trainers in the region. The training program supports service delivery in VCT, PMTCT, and clinical care and treatment. Building on the large network of VCT trainers already developed, USAID conducts refresher courses and technical updates for master and advanced trainers to ensure that their HIV/AIDS-related knowledge, skills, and attitudes comply with the latest available evidence.

USAID Country Support in the Caribbean

In the Caribbean, USAID also provides direct technical support to individual countries. PEPFAR places special emphasis on two focus countries: **Guyana** and **Haiti**. In addition, USAID implements HIV/AIDS bilateral programs in the Dominican Republic and Jamaica, while the Caribbean Regional Program covers Trinidad and Tobago, Suriname, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Grenada, Antigua and Barbuda, Dominica, and Barbados. Examples of USAID country support include the following activities and interventions:

- Supported prevention programs in Haiti emphasizing abstinence and being faithful for 345,700 people; counseling and testing for 128,600 people; palliative care and support for 38,700 people; and program assistance for 20,000 orphans and vulnerable children
- Reached more than 250,000 adolescents and youth in the Dominican Republic with abstinence and being faithful messages through the Annual Youth and Adolescent Song Contest, and 117,000 people in the Dominican Republic with testing and counseling services; supported PMTCT services in 82 facilities for almost 72,000 women and their babies; provided direct support to six outpatient clinics; and supported treatment for 11,552 HIV-positive patients and 7,669 orphans and vulnerable children through 18 community- and home-based care programs for children and families affected by HIV/AIDS
- Launched a media campaign in Suriname that significantly increased HIV counseling and testing between December 2005 and August 2006. Client satisfaction has improved and staff workload decreased since the implementation of same-visit testing
- Supported prevention programs in Guyana emphasizing abstinence and being faithful for 33,900 people and reached 28,300 people with counseling and testing services